

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3987

03979
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 2521

I. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Rural Centerville</u>				TOWN <u>Rural Centerville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Brownsville</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ANNIE MARIA BAKER</u>				<u>April 15 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>Colored</u>		<u>Single</u>		<u>Feb. 12-1876</u>	
						9. AGE last birthday: <u>79</u> yrs.	
						IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Maids</u>		11. BIRTHPLACE (State or foreign country): <u>M. Centerville Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Henry Baker</u>				14. MOTHER'S MAIDEN NAME: <u>Hester Curtis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Hennetta B. Wilson Centerville, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary thrombosis</u> DUE TO							
Antecedent cause(s) (b) <u>Arterio-sclerosis</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE <u>H. M. H. H. H.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-15-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Apr. 18-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Brownsville</u>		LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
DATE REC'D BY LOCAL REG. <u>4/18/55</u>		REGISTRAR'S SIGNATURE <u>Oliver Armstrong</u>		24. FUNERAL DIRECTOR: <u>Barton Bros. Centerville, Maryland</u>		ADDRESS	

BUREAU V. S.

APR 22 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3988

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03980

CERTIFICATE OF DEATH

Reg. Dist. No. 252

Items 13 & 14, Film G181, 5/13/55 fcy

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Centerville</u>		<u>3 1/2 yrs</u>		TOWN <u>Centerville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>VIVIAN</u> (Middle) <u>LINDSEY</u> (Last) <u>LAKE</u>				(Month) <u>April</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Oct-5-1864</u>	<u>90</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country):	
<u>Retired</u>				<u>Steam Engineer</u>		<u>Mass.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles H. Lake</u>				<u>Lilly L. Drennen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>None</u>		<u>none</u>		<u>Mr. Charles L. Andrew, Centerville, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
450.0 Immediate cause (a) <u>Chronic Dissection of the heart</u>							
Antecedent cause(s) (b) <u>Arteriosclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS:							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:				20. AUTOPSY?	
						Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Not while		HOW DID INJURY OCCUR?			
OF INJURY		M. work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>4-1</u> , 19 <u>53</u> , to <u>4-14</u> , 19 <u>55</u> that I last saw the deceased alive on <u>4-13</u> , 19 <u>55</u> , and that death occurred at <u>4</u> <u>30</u> m., from the causes and on the date stated above.							
SIGNATURE <u>H. J. Williams</u>				(DEGREE OR TITLE) <u>MD</u>		DATE SIGNED <u>4-16-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 16-55</u>		<u>Christfield</u>		<u>Centerville Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4/16/55</u>		<u>Glenn Armstrong</u>		<u>Barton Bros</u>		<u>Centerville Maryland</u>	

BUREAU V. M.

APR 22 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03981

3989

CERTIFICATE OF DEATH

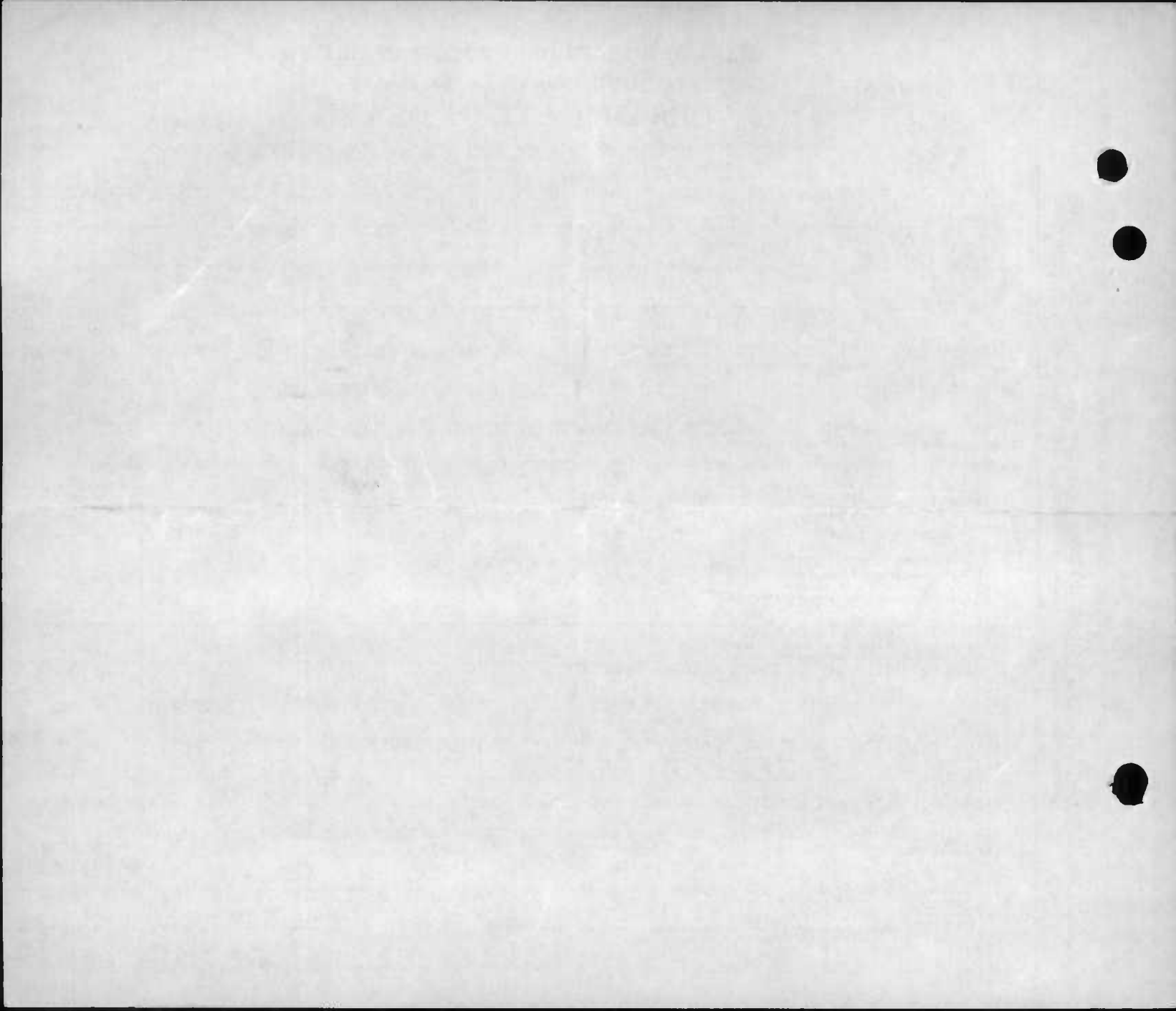
Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Queen Anne's</u> COUNTY <u>Q.A.</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rural - Chester</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Chester</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Cox's Neck</u>			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
<u>James</u>		<u>Allen</u>		<u>Morning</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. MONTHS	11. DAYS	12. HOURS
<u>M</u>	<u>C</u>	<u>Married</u>	<u>Dec. 1, 1891</u>	<u>62</u> ym.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Butler</u>				<u>Domestic</u>		<u>North Carolina</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Morning</u>				<u>Enis Munn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
<u>yes</u> <u>World War II</u>						<u>Carrie Morning Chester, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary Occlusion</u>						<u>2-3 min.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive Arteriosclerotic C-V Disease</u>						<u>3 yrs.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug.</u> , 19 <u>51</u> , to <u>April</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>55</u> , and that death occurred at <u>7:05</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Irwin J. Hoyt MD</u>				ADDRESS <u>Queenstown, Md.</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-12-55</u>		<u>Balto nat</u>		<u>md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4/11/55</u>		<u>W. Hedrick</u>		<u>George L. Nelson</u>		<u>1348 N. Calhoun St</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

03982

3990

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 252

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Centerville</u> LENGTH OF STAY (In this place) <u>14 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Centerville</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R. Route 3</u>		STREET ADDRESS (If rural, give location) <u>P.R. #3</u>	
3. NAME OF DECEASED (Type or Print) <u>Herman</u> (First) (Middle) <u>Paul</u> (Last) <u>Sn</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>11</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>4-10-78</u>
9. AGE last birthday <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Joe Paul</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Herman Paul Sn</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause (a) <u>Acute Distention of the Heart</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arterio-sclerosis</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>H. J. McPherson</u>		ADDRESS <u>Centerville, Md</u>	
DATE SIGNED <u>4-14-56</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>4-14-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Centerville</u>		LOCATION (City, town, or county) (State) <u>Centerville, Md</u>	
DATE REC'D BY LOCAL REG. <u>4-14-56</u>		REGISTRAR'S SIGNATURE <u>Glenn Armetrough</u>	
24. FUNERAL DIRECTOR <u>James B. Douthett</u>		ADDRESS <u>Centerville, Md</u>	

BUREAU V. E.

APR 22 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03983

3991

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Duval Ann</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Duval Ann</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Stevensville</i>				TOWN <i>Stevensville</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (Type or Print) <i>John Bradford Ringold</i>				4. DATE OF DEATH <i>Apr. 3 1955</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Apr. 8 1976</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Stevensville</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Benjamin Ringold</i>				14. MOTHER'S MAIDEN NAME <i>Harriet Martin</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. <i>215-20-0717</i>		17. INFORMANT & ADDRESS <i>Mrs. George Hamrick</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4210 IMMEDIATE CAUSE (A) <i>Asthmatic attack</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio Sclerosis Mitral regurgitation 4 yrs</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Apr 3 1955</i> to <i>Apr 3 1955</i> , that I last saw the deceased alive on <i>Apr 3 1955</i> , and that death occurred at <i>7:15 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Chas E Frye</i>				ADDRESS (Street, city, town, state) <i>Stevensville Md</i>		DATE SIGNED <i>3/4/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Apr. 7 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Iron Mt. Cem</i>		LOCATION (City, town, or county) <i>Stevensville Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Elizabeth D. Hopter</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i>		ADDRESS <i>Annapolis</i>	
DATE <i>4/13/55</i>							

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03984

3992

CERTIFICATE OF DEATH

Reg. Dist. No. 25-2

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Robert</u>	(Middle) <u>Emory</u>	(Last) <u>Solloway</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 3, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	9. AGE last birthday <u>84</u> ym. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Solloway</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Delahay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Margaret Lohr - Centreville</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422d
Immediate cause(a) Inanition

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis C-V Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan, 1955, to April, 1955, that I last saw the deceased alive on April 9, 1955 and that death occurred at 6:15 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 15-55</u>	<u>Christened</u>	<u>Centreville</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/16/55</u>	<u>Chas. Armstrong</u>	<u>Barton Bros</u>	<u>Centreville Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. M.

APR 22 1955

RECEIVED

3993

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Chester</u>		LENGTH OF STAY (in this place) <u>all his life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		OR TOWN <u>Chester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u>				STREET ADDRESS (If rural give location) <u>Dominion</u>			
3. NAME OF DECEASED: (Type or Print) <u>Lery</u> (First) <u>Enright</u> (Middle) <u>Thomas</u> (Last)				4. DATE OF DEATH: <u>April 12</u> 19 <u>55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug 10 - 1879</u>	9. AGE last birthday: <u>75</u> yrs.	10. UNDER 1 YEAR	11. UNDER 24 HRS.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Distillery</u>		11. BIRTHPLACE (State or foreign country): <u>Chester Md -</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William Thomas</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Rebecca Stalling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>214-34-8634</u>		17. INFORMANT & ADDRESS: <u>Mr Albert Gerty, Chester Maryland</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Coronary occlusion (embolus)</u>						<u>April 12, 1955</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>coronary insufficiency</u>						<u>about 2 years</u>	
(c) <u>Arteriosclerosis general + coronary</u>						<u>5 years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 10, 1954</u> , to <u>April 12, 1955</u> , that I last saw the deceased alive on <u>April 11, 1955</u> , and that death occurred at <u>8 15 P.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Theron Sattelmair M.D.</u>				ADDRESS <u>Stevensville Md.</u>		DATE SIGNED <u>4/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 15 - 55</u>		<u>Stevensville Md</u>		<u>Stevensville Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>April 15, 1955</u>		<u>Elizabeth Hooper</u>		<u>Barton Bros</u>		<u>Centerville Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 19 1955

BUREAU V. S.

03986

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3994
Olivia C. Woodring

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sudlersville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chestertown</u> 14-37-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walraven Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>High St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Olivia</u> (Middle) <u>C</u> (Last) <u>Woodring</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4/30/55</u> 19 <u>55</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>1/31/1884</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dietician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private school</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Israel Woodring</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Yost</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>231-38-1358</u>	
		17. INFORMANT AND ADDRESS <u>Ella S. Crow</u> <u>Chestertown, Md.</u>	
18. MEDICAL CERTIFICATION			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1
Immediate cause

(a)

Acute Cardiac Distention

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Chronic myocarditis

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

General Arteriosclerosis

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

NO
21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒TIME (Month) (Day) (Year) (Hour) OF INJURY 1/1 m.INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1955, to April 30, 1955, that I last saw the deceased alive on April 29, 1955, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE REC'D BY LOCAL REG.

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial 5/3/55 Church Hill Cem. Church Hill, Md.
May Edgar L. Laner J. Willis Wells - Chestertown, Md.

MARGIN RESERVED FOR BINDING

VS. A15

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MAY 10 1965

BUREAU V. S.